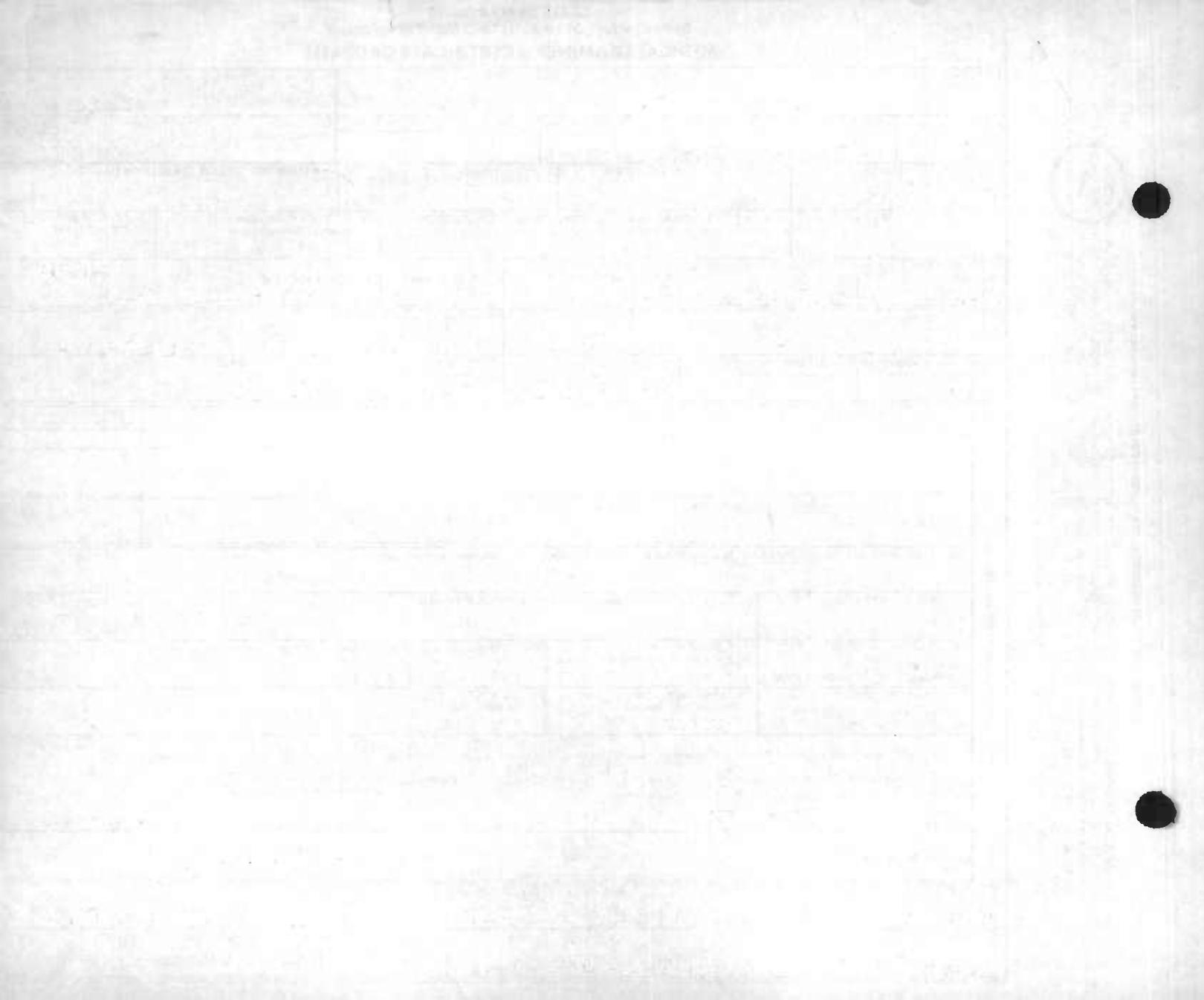


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE GIVEN TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
Stephen			G.	Benton		<input checked="" type="checkbox"/>	4	?	1984	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
Male	White	AUGUST 18 1951 28	YRS.			4	22	84	a	11:30	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH						
New York		U. S. A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Kent County,						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Worton Creek										21234			
13a. STATE MARYLAND		13c. CITY OR TOWN CAROLY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9000 Hines Road							
14. FATHER'S NAME GEORGE		MIDDLE A.	LAST Benton	15. MOTHER'S MAIDEN NAME Doreen					DePalma				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 813 68 1323		17. INFORMANT Family Records		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9840 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
							<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY ? P.M. 4 ? 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET unknown		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 26 1984		23c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH		23d. LOCATION CITY OR TOWN 255 Ex		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Evans Chapel of Memorials HARFORD ROAD		ADDRESS 8800		25. DATE REC'D. BY REGISTRAR JUN 4 1984		26. REGISTRAR'S SIGNATURE Julia David-Randall							
20M 4/82													

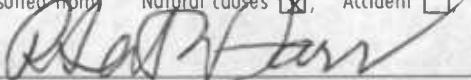


FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3-Done 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	Month	Day	Year	2b. HOUR
Norman Franklin Blackiston						4-2				1984 2:25	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD					
Male	White	Oct. 26, 1905	77 yrs.	MONTHS	DAYS	MONTH	DAY	YEAR	2d. HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED	<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH		Kent	
Maryland		U.S.A.		WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown			Kent & Queen Annes Hosp. Farming			Farming			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Queen Annes			Sudlersville			Box 72		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Thomas			Franklin	Blackiston		Heneritta			Harris	Blackiston	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			217-30-3152			Hilda Blackiston			Sudlersville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
4149 IMMEDIATE CAUSE (a) Cardiac arrest secondary to Coronary Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 											
EXAMINER'S NAME (Type) Robert W. Farr, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE April 5, 84			23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery			23d. LOCATION (City or Town) Crumpton (County) Md. (State)		
Burial											
24. FUNERAL DIRECTOR			ADDRESS			APR 18 1984			DATE		
Edward Fellows & Son Millington, Md.											

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11790 79 349981 285182 11030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 11045				
1. DECEASED NAME (TYPE OR PRINT)			FIRST HARRY Earle Cooper			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 12 DAY 08 YEAR 1898			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.		
10. CITY OR TOWN OF DEATH Chesterstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY HARDWARE					
13a. STATE MD. 13b. COUNTY Q.A.			13c. CITY OR TOWN KINGSTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT 4 21620					
14. FATHER'S NAME FIRST GEORGE MIDDLE N. LAST COOPER			15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE CATHARINE LAST WOOD			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212 03 0955			17. INFORMANT 21620 ADDRESS 241 HIGH ST. HARRISON M. COOPER CHESTERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409			DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			22a. DATE SIGNED 4/30/84					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from 4-29-1984, to 4-30-1984, that (I) (we) last saw the deceased alive on 4-29-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE A.C. Dick MD.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS CHESTERSTOWN MD. 21620.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/3/84			23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY			23d. LOCATION CITY OR TOWN CHESTERSTOWN COUNTY Kent STATE Md.					
24. FUNERAL DIRECTOR NAME Marvin V. Williams Jr.			25a. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 4 1984 June Davidson Pendleton											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 was any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 11046				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Daniel Zachary Gibson Jr.						4			23	84		1:30 P.M.		
3. SEX male			4. RACE white		5. DATE OF BIRTH Month Day Year January 26, 1908		6. AGE IN YEARS LAST BIRTHDAY 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED XX MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			MD.				
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator & College President		12b. KIND OF BUSINESS OR INDUSTRY							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 103 S. Water St. 21620				
14. FATHER'S NAME FIRST Daniel Z. Gibson			MIDDLE (Sr.)	LAST	15. MOTHER'S MAIDEN NAME FIRST Mellie Rice		MIDDLE	LAST	21620					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW 2			16b. SOCIAL SECURITY NO. Navy 247 34 2835		17. INFORMANT Henel S. Gibson		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE			ADDRESS 103 S. Water St. Chestertown, Md.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3320 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD and BRONCHOPNEUMONIA		DUE TO, OR AS A CONSEQUENCE OF (c) END STAGE PARKINSON'S DISEASE									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>4-23</u> 19 <u>84</u> , to <u>4-23</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, check here.)														
22b. SIGNATURE Harry Paul Ross			22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4-24-84							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross			22f. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/26/84		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory		23d. LOCATION CITY OR TOWN Wilmington, Del.							
24. FUNERAL DIRECTOR NAME Willis Wells			ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR APR 30 1984			25b. REGISTRAR'S SIGNATURE Sue Davidson Randall						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked "Yes", Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Armolene Ruth Hawkins					Hawkins			April 24, 1984						2:33 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
Female		Negro Black		Month 3 - Day 4 - Year 99			86 YRS			MONTHS			DAYS HOURS MIN.					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		United States		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's Hosp.										Laundress			MD.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland		Kent		Rock Hall			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2 Box 177			21661					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Harry		NMN		Williams			Mary			Hester			Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Unknown		219-34-3203		Mrs. HESTER W. THOMPSON, R.F.D. #1, ROCKHALL, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Generalized Arteriosclerosis @ At Amputation of leg, ③ Senile</u>																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/18/84</u> to <u>4/24/84</u> , that (I/we) last saw the deceased alive on <u>4/19/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>KIN KUE WUN</u>		22c. DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/24/84</u>										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN		22f. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>4/28/84</u>			23c. NAME OF CEMETERY OR CREMATORIAL AARON CHAPEL			23d. LOCATION ROCKHALL, MD.			23e. COUNTY STATE							
24. FUNERAL DIRECTOR <u>Smithwood Chestertown</u>		24. ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>MAY 2 1984</u>			25b. REGISTRAR'S SIGNATURE <u>Jean Davidson-Bender</u>										
DHMH - 16 50M 4/B3 (VRA 15, 4)																		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 11048			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Margaret Theresa Murphy						April 26, 1984			7:55 a.m.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		White		September 5, 1913			70 YRS.			MONTHS DAYS			
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Ireland		USA			Kent								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent & Queen Anne's Hospital			Nurse								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21661			
Maryland		Kent		Rock Hall				P.O. Box					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John Fitzgibbon		Anastasia Moore											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS						
no		109 01 3076			Mary Ann Johnsson		New York City						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>HSCW D</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal failure -</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to 4/26, 1984, that (I) (we) last saw the deceased alive on 4/25/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												84	
22b. SIGNATURE <i>Patricia Molony</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/26/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony		22e. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4/30/84		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Catholic			23d. LOCATION Rock Hall, Md.						
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		ADDRESS Chestertown, Md.						25a. DATE REC'D. BY REGISTRAR APR 30 1984				25b. REGISTRAR'S SIGNATURE <i>Lilia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 1 0 4 9					
										REG. NO.					
1 - STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Ray Miskaman Robinson						April 16, 1984			8:35 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			White			10 20 03			80 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Kent						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Chestertown			Kent & Queen Annes' Hospital Inc.			Farmer			Farm						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Marydel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 154 21649				
14. FATHER'S NAME FIRST Henry			MIDDLE M.			LAST Robinson			15. MOTHER'S MAIDEN NAME FIRST Ella			MIDDLE J.		LAST Whaley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS			
No			213-18-5045			Evelyn Taylor			Marydel, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable cerebral thrombosis.</u>															
4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Obstructive pulmonary disease, respiratory acidosis.</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>R. Est. M. Ann</u> DEGREE <u>M.R.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <u>4/17/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4-19-84			23c. NAME OF CEMETERY OR CREMATORIAL Templeville Cemetery			23d. LOCATION CITY OR TOWN Templeville COUNTY CA STATE MD						
24. FUNERAL DIRECTOR NAME <u>John E. Bourdeau</u> ADDRESS <u>Greensboro, MD</u>										25a. DATE REC'D. BY REGISTRAR <u>APR 27 1984</u> 25b. REGISTRAR'S SIGNATURE <u>Juli David Rodelle</u>					
DHMH - 16 50M 4/83 (VRA 15, 4)															

East

West

North

South

Up

Down

Left

Right

Front

Back

Top

Bottom

Inside

Outside

Front

Back

Left

Right

Up

Down

Front

Back

Inside

Outside

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranfer permit. Then please remove carbon paper. pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked "Yes" to any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 1 0 5 0							
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR April 7, 1984							2b HOUR 4:10 P.M.							
1 DECEASED NAME (TYPE OR PRINT) NATALIE H. SAUTER			FIRST MIDDLE LAST			3a DATE OF BIRTH MONTH DAY YEAR May 2, 1900		3b AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS							
3c SEX female			4c RACE white			5c CITIZEN OF WHAT COUNTRY? USA		6c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 24 HRS HOURS MIN							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.			7b CITIZEN OF WHAT COUNTRY? USA			8c BALTIMORE CITY OR COUNTY OF DEATH Kent		MD.									
10 CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13a COUNTY Kent			13b CITY OR TOWN Rock Hall		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS Bay Side Ave.		21661					
14 FATHER'S NAME FIRST MIDDLE LAST Ernest T. Hanefeld			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Jackquins			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. 215 50 2153				17 INFORMANT ADDRESS Patricia S. DuVall - Rock Hall, Md.		21661	
18c CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Chronic obstructive lung disease & Superimposed infection DUE TO, OR AS A CONSEQUENCE OF (b) disease & Superimposed infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) infection DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCVD																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)											
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) (this hospital) attended the deceased from 4-7 19 84 , to 10-22 19 84 , that (I) (we) last saw the deceased alive on 4-7 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE Harry Paul Ross MD			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22d DATE SIGNED 4/7/84									
22d PHYSICIAN (NAME, TYPE OF PRINT) Harry Paul Ross			22e ADDRESS Chestertown, Md.														
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 4/10/84			23c NAME OF CEMETERY OR CREMATORY Westminister Cem.		23d LOCATION CITY/DEPTN COUNTY STATE Phila. Pa. Belmont Ave.									
24 FUNERAL DIRECTOR Willie Wells			25a ADDRESS Chestertown, Md.					25b DATE REC'D. BY REGISTRAR APR 10 1984				25c REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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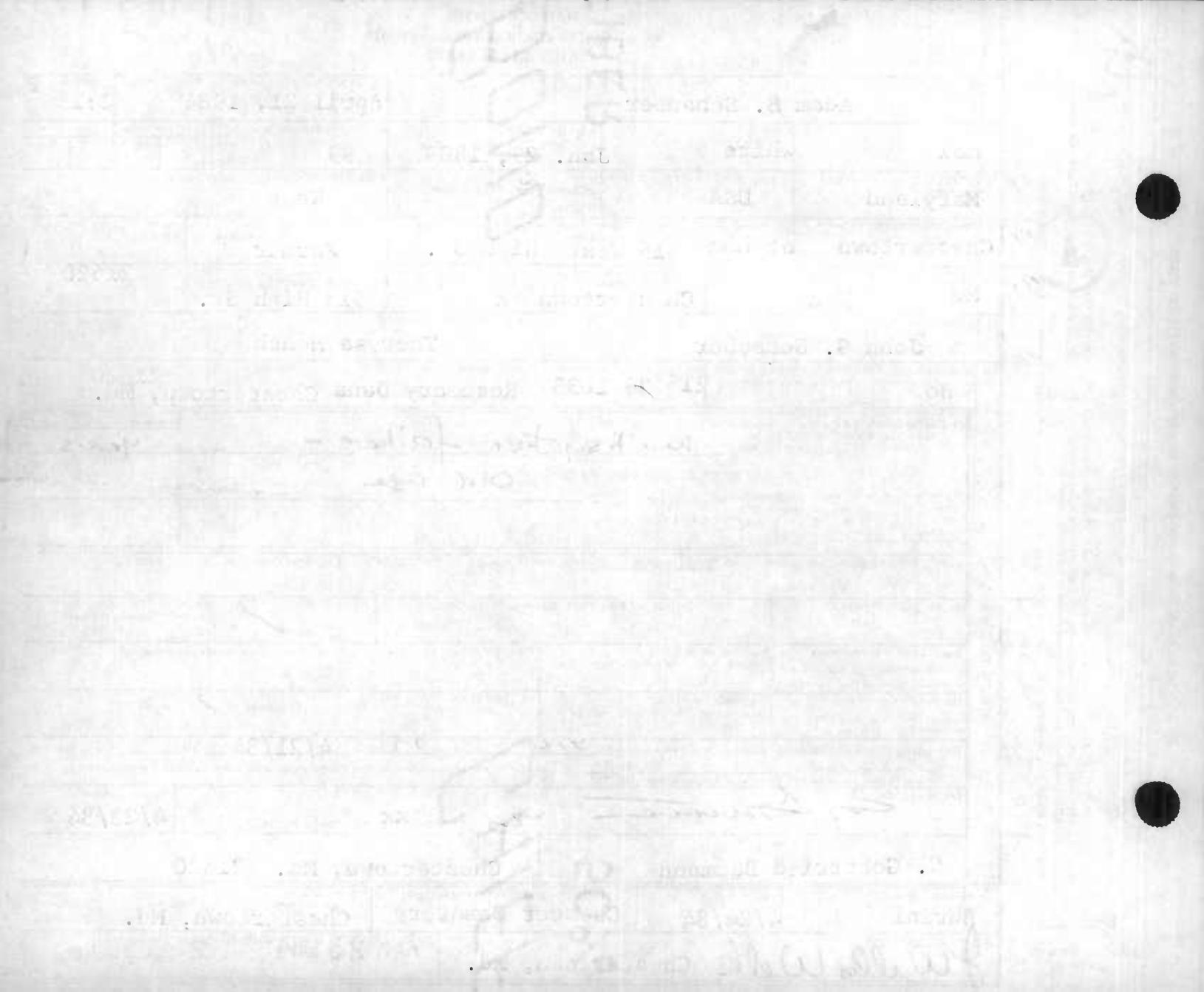
(M) will send out

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the body of the document and removed carbon papers, pages 1 and 2 should be attached to page 3 and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is modified or item 18 shows only injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 11051			
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR April 21, 1984								2b. HOUR P 2:15 M			
I. DECEASED NAME (TYPE OR PRINT) Adam B. Schauber				LAST				6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1885				9. BALTIMORE CITY OR COUNTY OF DEATH Kent							
7a. BIRTHPLACE Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10. CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION at home 515 West High St.			
13a. STATE Md		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 515 High St. 21620			
14. FATHER'S NAME FIRST MIDDLE LAST John G. Schauber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Mench											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215 36 1033				17. INFORMANT Rosemary Dana Chestertown, Md. 21620				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multi system failure - 7999 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 77 , to 4/21/84 , 19_____, that (I) (we) lost sow the deceased alive on 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE as Baumann DEGREE BS															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann			22e. ADDRESS Chestertown, Md. 21620			22f. DATE SIGNED 4/23/84									
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 4/24/84				23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery				23d. LOCATION CITY OR TOWN Chestertown, Md.			
24. FUNERAL DIRECTOR NAME J. Willis Wells				ADDRESS Chestertown, Md.				25a. DATE RECEIVED APR 25 1984				25b. REGISTRAR'S SIGNATURE Jane Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, sign the back of the certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 1 0 5 2							
1 - FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Lola			MIDDLE Mae			LAST Smith		2d. DATE OF DEATH MONTH April		DAY 2, 1984		2b. HOUR 8:05a M			
3. SEX Female		4. RACE White			5. DATE OF BIRTH MONTH 6			DAY 19		YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS 79		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent									
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Homemaker									
13a. STATE Md.		13b. COUNTY KENT		13c. CITY OR TOWN CHESTERTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS NORTH QUEEN ST.		14. FATHER'S NAME FIRST GEORGE MIDDLE WASHINGTON LAST CARTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-42-0627			17. INFORMANT MARTHA ANN RIDDLE			ADDRESS PO BOX 174 21620									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Breast metastatic Ca.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>M. Molony</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/5/84									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK A. MOLONY, M.D.		22f. ADDRESS KENT & QUEEN ANNE'S HOSPITAL CHESTERTOWN, MARYLAND 21620															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/4/84			23c. NAME OF CEMETERY OR CREMATORIAL CHESTER CEMETERY			23d. LOCATION CITY OR TOWN CHESTERTOWN		COUNTY KENT		STATE MD.					
24. FUNERAL DIRECTOR Marvin V. Wilmer Jr.		25a. DATE REC'D. BY REGISTRAR 4/4/84			25b. REGISTRAR'S SIGNATURE <i>John Davidson Parker</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8411053						
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR					
		Emma Marie Snowman			April 26, 1984	3:00 PM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		April 11, 1890	94	YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				
Baltimore, MD		U.S.A.			Kent County		Chestertown				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Magnolia Hall		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		216601	
Maryland		Kent		Rock Hall		Box 264 Haven Road					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Aaron Geipe						Margaret Batchelor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				217-18-9337-A		Violet E. Knell, Rock Hall, MD 21661					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Natural C HF</i>											
4292											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCI</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M. J. Snider</i> DEGREE <i>MD</i>											
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>4/27/84</i>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>04/29/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's</i>		23d. LOCATION CITY OR TOWN <i>Chestertown</i>		COUNTY <i>Kent</i>		STATE <i>MD</i>	
24. FUNERAL DIRECTOR NAME <i>Tom Helfenbein Funeral Homes, Chester, MD 21619</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 4 1984</i>				25b. REGISTRAR'S SIGNATURE <i>J. H. Jackson-Wendell</i>					
BP _____											
DHM - 16 50M 4/83 (VRA 15, 4)											

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Set of 100

1000 pieces

various sizes

1000 pieces

1000

plastic

1000 pieces

1000

1000

Cards

300

Set of 100

1000 pieces

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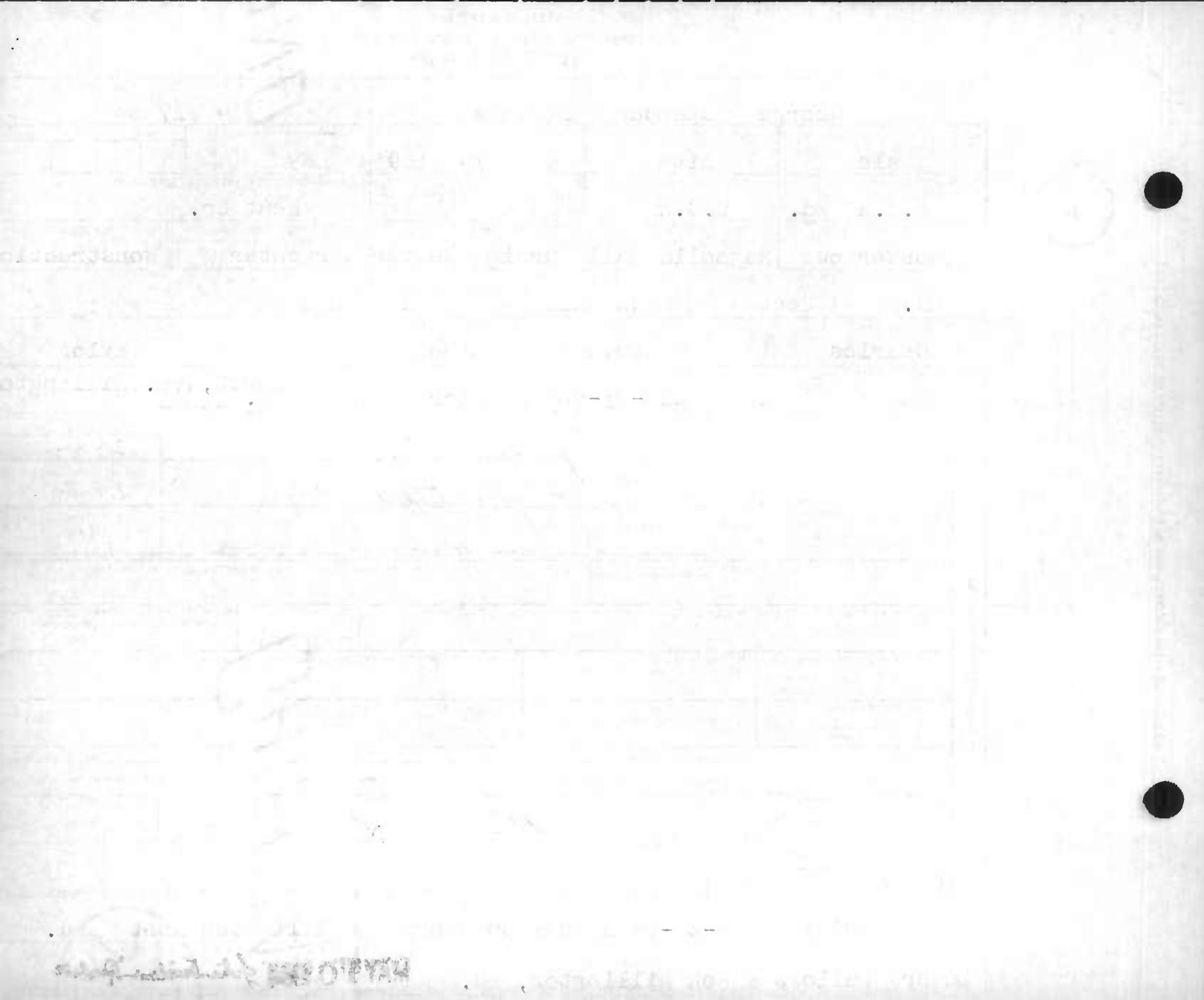
Set of 1000 pieces

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranport permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
REG. NO. 841034																		
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		George Spencer Stevens										4 17 84						
3. SEX		4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN						
Male		White			MONTH 4 DAY 14 YEAR 1895			89 YRS.										
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.								
U.S.A Md.		U.S.A						Kent Co.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Chestertown		Magnolia Hall Nursing Center			Carpenter			Construction		21661								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS										
Md.		Kent		Rock Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD#1										
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST						
		Charles		NMM		Stevens		Ethel				Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Yes WW		218-05-9608			Taylor Stevens		Hurtt Ave. Millington Md. 21651		24 hrs.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).																		
3109 <i>pneumonia</i>																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <i>post fractured hip</i>												2 months.						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Organic Brain Syndrome</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Organic Brain Syndrome</i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Michael P. Bex</i>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED May 10 84											
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Bex		22g. ADDRESS P.O. Box 140 Millington, Md. 21651																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-21-84			23c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery		23d. LOCATION CITY OR TOWN Millington		COUNTY Kent		STATE Md.							
24. FUNERAL DIRECTOR NAME Edward Fellows & Son		ADDRESS Millington, Md.			25a. DATE REC'D. BY REGISTRAR May 10 84		25b. REGISTRAR'S SIGNATURE <i>Jeanne Wilson-Pendell</i>											



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 2 and 3 with the State Department of Health, prior to burial, cremation, or removal within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

1. DECEASED-NAME (Type or Print)	First RHODA	Middle PAULINE	Last TEAT	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 4	Day 16	Year 1984	2b. HOUR 2:15			
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH OCT. 30, 1910	6. AGE (In years lost birthday YRS.) 74	IF UNDER 1 YEAR MONTHS Y	IF UNDER 24 HRS. DAYS Y	HOURS H	MIN M	2c. DATE PRONOUNCED DEAD Month 4	Day 16	Year 1984	2d. HOUR 2:15
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH KENT								
10. CITY OR TOWN OF DEATH CHESTERTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or never address) KENT & QUEEN ANNES HOS			12a. USUAL OCCUPATION (Kind of work done during working hours, even if retired.) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Q.A.	13c. CITY OR TOWN MILLINGTON	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER RT 1 BOX 169	21651						
14. FATHER'S NAME JOSEPH	First RINGGOLD	Middle	Last	15. MOTHER'S MAIDEN NAME JULIA	First CLARK	Middle	Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 222-09-0136	17. INFORMANT EARL TEAT SR. husband same	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> lost.											
(b) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Robert Farr</i>		EXAMINER'S NAME (Type) DR. ROBERT FARR		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-20-84	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 4-19-84		23c. NAME OF CEMETERY OR CREMATORIAL CRUMPTON CEM.		23d. LOCATION (City or Town) CRUMPTON, Q.A. MD		(County)		(State)	
24. FUNERAL DIRECTOR FELLOWS F.H. BOX 270 MILLINGTON, MD 216		ADDRESS		25a. REC'D BY REGISTRAR APR 25 1984		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Petrelli</i>					

2025 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8411058					
												REG. NO. 11056					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST NMN			MIDDLE Wilson			LAST					
Emily																	
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH Jan. DAY 20, YEAR 1902			6. DATE OF DEATH April 4, 1984			2b. HOUR 6:32 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.					
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home								
13. STATE Maryland			13c. COUNTY Queen Anne's			13d. INSIDE CITY LIMITS? Inside			13e. STREET ADDRESS / ZIP CODE Dogwood Village 21668								
14. FATHER'S NAME FIRST (unknown) MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST (unknown) MIDDLE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218033680			17. INFORMANT Mrs. Sally Coutu, Falls Church, Va.			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Gram negative Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) ca (R) kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } } DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several months					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Disseminated Intravascular Coagulation																	
19a. DATE OF OPERATION 3/26/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Reproductive - ca			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3131			21f. LOCATION STREET 3131 CITY OR TOWN 414 COUNTY 1989 STATE 1989											
22a. I certify that (I) (this hospital) attended the deceased from 3131, 1989, to 414, 1989, that (I) (we) last saw the deceased alive on 414, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>C. Dunn</i>			22c. DEGREE Lay			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/1/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/7/84			23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton COUNTY Caroline STATE MD								
24. FUNERAL DIRECTOR NAME Moore Funeral Home, 1230 2nd St. Denton			25a. DATE REC'D. BY REGISTRAR APR 12 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendell											

the first time I have seen a
large number of them. They
are very small, about 1/2 in.
long, and are found in great
numbers in the mud along
the river banks. They are
brownish-green in color and
have a very strong smell.

They are very
common in the
area around the
river.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign here.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or checked, as any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 11057	
I. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR A 11:40M		
Margery E. ZIMMERMANN							April 15, 1984						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.			
female		white		11/10/1924			59 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. X MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.			
Rock Hall		RFD 1 Bx 202A (At Home)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> XX <input checked="" type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE Rd# 1 Bx 202A 21661			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet McCaughy RFD # 1 Box 202A									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO 049 14 9861				17. INFORMANT Raymond Zimmerman Rock Hall, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC ADENOCARCINOMA OF LUNG</u> DOUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from 7/26, 1983, to 4/15/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Virginia U. Collier</u>		22c. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/16/84			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Virginia U. Collier		22f. ADDRESS Chestertown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/16/84		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Crematory			23d. LOCATION CITY OR TOWN Wilmington, Dela. COUNTY STATE						
24. FUNERAL DIRECTOR NAME <u>J. Willis Wells</u>		25a. DATE REC'D. BY REGISTRAR APR 17 1984						25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>					
ADDRESS Chestertown, Md.													

